PLEASE STAND BY

YOU WILL HEAR SILENCE UNTIL THE PRESENTATION BEGINS

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The HIV/STD/TB/Hepatitis Program and Dakotas AIDS Education and Training Center (DAETC) conduct monthly Lunch and Learn Webinars for health care professionals in North and South Dakota.

Each month a new topic will be held from 12:00 p.m. to 1:00 p.m. CST on the **fourth Wednesday of the month.**

Next L&L : February 14, 2018

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https://www.ndhealth.gov/hiv/Provider/

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DISEASE 101: HIV AND STDS

JANUARY 24, 2018

SARAH WENINGER, MPH

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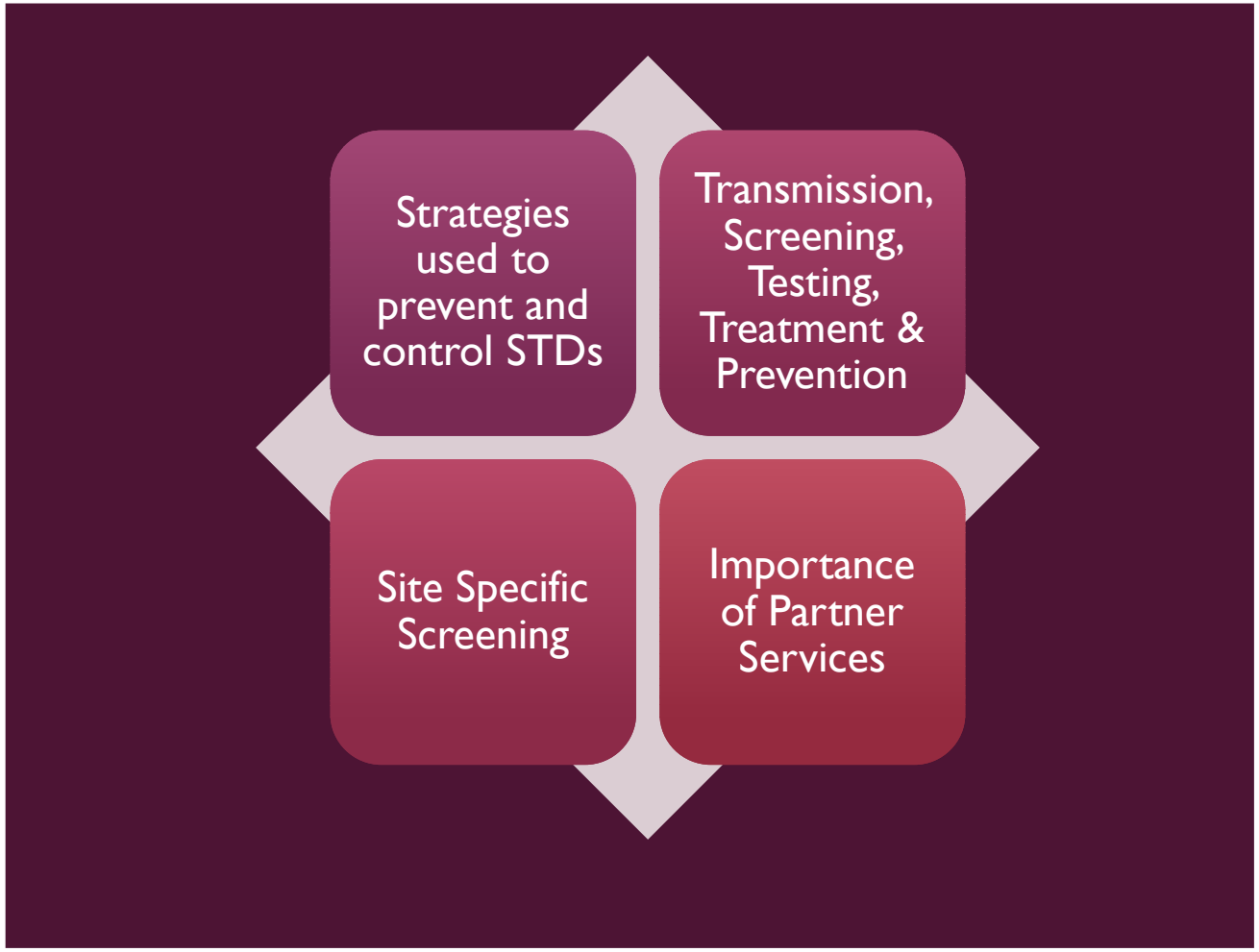
OBJECTIVES



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1. Risk Assessment, Education and Counseling

2. Pre-Exposure Vaccination

3. Screening Asymptomatic Individuals

4. Effective Diagnosis, Treatment, Counseling, Follow-Up of Infected Persons

5. Evaluation, Treatment and Counseling of Sex Partners

THERE ARE 5 MAJOR STRATEGIES FOR THE PREVENTION AND CONTROL OF STDS.

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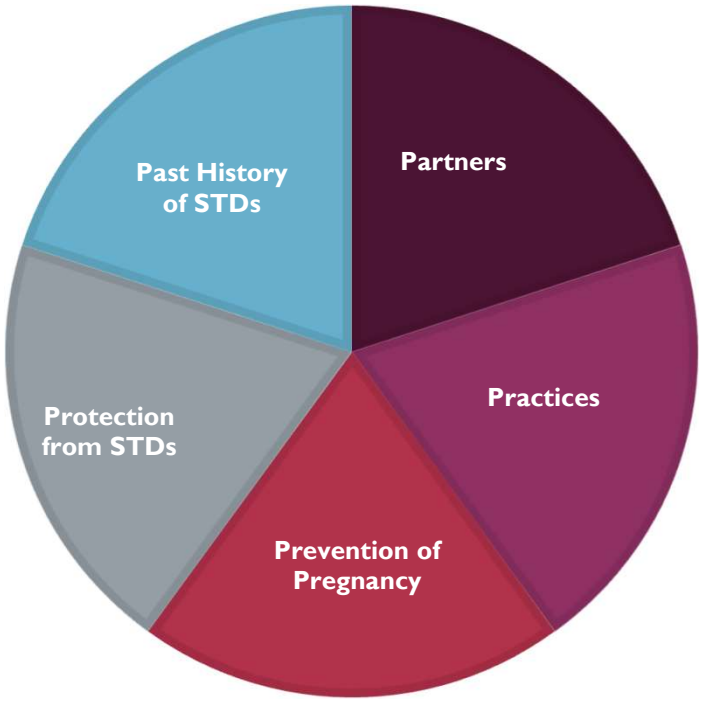
THE FIVE P'S IN A SEXUAL HISTORY



Goal: Facilitate Rapport with Patients

- Open-Ended Questions
- Understandable, Nonjudgmental Language
- Normalizing Language

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CHLAMYDIA

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CHLAMYDIA (*CHLAMYDIA TRACHOMATIS*)

- The Most Commonly Reported Nationally Notifiable Disease
  - In 2016 1.59 Millions cases of chlamydia were reported to CDC from 50 states and the District of Columbia
- It is estimated that 1 in 20 sexually active young women aged 14-24 years has chlamydia.
- Mean Incubation Period is Variable, At Least 1 Week

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CHLAMYDIA MANIFESTATIONS IN WOMEN AND MEN

Chlamydia in MEN

- Only About 10% Show Symptoms
- **Urethritis**, with a mucoid or watery urethral discharge and **dysuria**.
- A minority of infected men develop epididymitis (with or without symptomatic urethritis), presenting with unilateral testicular pain, tenderness, and swelling.

Chlamydia in WOMEN

- 5-30% May Show Symptoms
- Bacteria initially infect the cervix and the urethra:
  - **Cervicitis:** mucopurulent endocervical discharge, easily induced endocervical bleeding
  - **Urethritis:** pyuria, dysuria, urinary frequency
- Infection can spread from the cervix to the upper reproductive tract (i.e., uterus, fallopian tubes), causing pelvic inflammatory disease (PID).
  - Symptomatic **PID** occurs in about 10 to 15 percent of women with untreated chlamydia.
  - PID Symptoms: Lower abdominal pain, mild pelvic pain, increased vaginal discharge, irregular menstrual bleeding, fever, pain with intercourse, painful and frequent urination, abdominal tenderness
  - Both acute and subclinical PID can cause permanent damage to the fallopian tubes, uterus, and surrounding tissues which can lead to chronic pelvic pain, tubal factor infertility, and ectopic pregnancy.

- Anal Sex: Symptoms of proctitis (e.g., rectal pain, discharge, and/or bleeding)
- Sexually acquired chlamydial conjunctivitis can occur in both men and women through contact with infected genital secretions
- While chlamydia can also be found in the throats of women and men having oral sex with an infected partner, it is typically asymptomatic and not thought to be an important cause of pharyngitis

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Pre-Term Delivery, Conjunctivitis, Pneumonia

- Chlamydial conjunctivitis: 18-44%
- Chlamydia pneumonia: 3-16%

Screening: First Prenatal Visit

- Screening In Third Trimester: At Increased Risk
  - Women Under 25, Have a New Sex Partner, Sex Partner with Concurrent Partners or a Sex Partner with a Sexually Transmitted Disease

Test of Cure: 3 to 4 weeks after Completing Treatment

Retesting 3 Months after Treatment

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WOMEN WITH UNTREATED CHLAMYDIA CAN PASS THE INFECTION TO THEIR BABY.

WHO SHOULD I SCREEN?

Women	**•Sexually active women under 25 years of age** **•Sexually active women aged 25 years and older if at increased risk** **•Retest approximately 3 months after treatment**
Pregnant Women	•All pregnant women under 25 years of age •Pregnant women, aged 25 and older if at increased risk •Retest during the 3rd trimester for women under 25 years of age or at risk •Pregnant women with chlamydial infection should have a test-of-cure 3-4 weeks after treatment and be retested within 3 months
Men	•*Consider screening young men in high prevalence clinical settings or in populations with high burden of infection (e.g. MSM)
Men Who have Sex With Men (MSM)	**•At least annually for sexually active MSM at sites of contact (urethra, rectum) regardless of condom use** **•Every 3 to 6 months if at increased risk**
Persons with HIV	•For sexually active individuals, screen at first HIV evaluation, and at least annually thereafter[8] •More frequent screening for might be appropriate depending on individual risk behaviors and the local epidemiology

https://www.cdc.gov/std/tg2015/screening-recommendations.htm

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CHLAMYDIA TREATMENT

Recommended:

Azithromycin 1 g orally in a single dose

OR

Doxycycline 100 mg orally twice a day for 7 days

- **Retesting: 3 Months after Treatment**
- Test of Cure: Not Generally Recommended

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CHLAMYDIA TREATMENT: PREGNANCY

Recommended:

Azithromycin 1 g orally in a single dose

Alternative Regimens:

- **Amoxicillin 500 mg orally three times a day for 7 days OR**
- **Erythromycin base 500 mg orally four times a day for 7 days**
- **Erythromycin base 250 mg orally four times a day for 14 days**
- **Erythromycin ethylsuccinate 800 mg orally four times a day for 7 days**
- **Erythromycin ethylsuccinate 400 mg orally four times a day for 14 days**

- Reminder: Test-of-cure recommended for pregnant women 3-4 weeks after completion of therapy because of potential sequelae.

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EXPEDITED PARTNER THERAPY (EPT)

- Treatment of partners without an intervening personal assessment by a health-care provider
- Accepted method of treatment of CT and GC infections in ND as of January 2009
- (ND Administrative Code, Chapters 61-04-04-01 Unprofessional Conduct, 54-05-03.1-10 Authority to Prescribe, 50-05-01 Expedited partner therapy).
- Guidelines for medical providers, website, EPT toolkit under development

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GONORRHEA

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GONORRHEA (*NEISSERIA GONORRHOEAE*)

- In 2016, 468,514 cases of gonorrhea were reported to CDC. (18% Increase from 2015)
  - CDC estimates that approximately 820,000 new gonococcal infections occur in the United States each year, and that less than half of these infections are detected and reported to CDC.
- Incubation Period is Usually 2 to 7 Days
- *N. gonorrhoeae* infects the mucous membranes of the reproductive tract, including the cervix, uterus, and fallopian tubes in women, and the urethra in women and men. *N. gonorrhoeae* can also infect the mucous membranes of the mouth, throat, eyes, and rectum.

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GONORRHEA MANIFESTATIONS IN WOMEN AND MEN

Gonorrhea in MEN

- Most Often Asymptomatic
- Dysuria or a white, yellow, or green urethral discharge
- If infection is complicated by epididymitis, men with gonorrhea may also complain of testicular or scrotal pain. In rare cases, this may lead to infertility.

Gonorrhea in WOMEN

- Most Asymptomatic
- Even when a woman has symptoms, they are often so mild and nonspecific that they are mistaken for a bladder or vaginal infection
- Symptoms include: dysuria, increased vaginal discharge, or vaginal bleeding between periods.
- Women with gonorrhea are at risk of developing serious complications from the infection, regardless of the presence or severity of symptoms.
  - Pelvic inflammatory disease (PID).

- Symptoms of rectal infection in both men and women may include discharge, anal itching, soreness, bleeding, or painful bowel movements. Rectal infection also may be asymptomatic.
- Pharyngeal infection may cause a sore throat, but usually is asymptomatic.
- If left untreated, gonorrhea can also spread to the blood and cause disseminated gonococcal infection (DGI). DGI is usually characterized by arthritis, tenosynovitis, and/or dermatitis. This condition can be life threatening.

WHO SHOULD I SCREEN?

Women	**•Sexually active women under 25 years of age** **•Sexually active women age 25 years and older if at increased risk** **•Retest 3 months after treatment**
Pregnant Women	•All pregnant women under 25 years of age and older women if at increased risk •Retest 3 months after treatment
Men Who have Sex With Men (MSM)	**•At least annually for sexually active MSM at sites of contact (urethra, rectum, pharynx) regardless of condom use** **•Every 3 to 6 months if at increased risk**
Persons with HIV	•For sexually active individuals, screen at first HIV evaluation, and at least annually thereafter •More frequent screening for might be appropriate depending on individual risk behaviors and the local epidemiology

https://www.cdc.gov/std/tg2015/screening-recommendations.htm

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UNCOMPLICATED GONORRHEA INFECTION

Recommended:

Ceftriaxone 250 mg IM

PLUS

Azithromycin 1 g orally

- Alternatives:

  Cefixime 400 mg PLUS Azithromycin 1 gram

  - Can use alternative regimen for EPT

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ADDITIONAL TREATMENT OPTION FOR GC

- Monotherapy of 2g Azithromycin is Not Recommended
- New treatments:

Gentamicin 240 mg IM + Azithromycin 2 g PO

Or

Gemifloxacin 320 mg PO + Azithromycin 2 g PO

CDC STD TX Guidelines, pg. 63
The Efficacy and Safety of Gentamicin Plus Azithromycin and Gemifloxacin Plus Azithromycin as Treatment of Uncomplicated Gonorrhea; Kirkaldy, CID 2014

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PUBLIC HEALTH CONCERN: ANTIBIOTIC RESISTANCE

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TEST OF REINFECTION VS. TEST OF CURE - GONORRHEA

Test of Reinfection

- There is a high prevalence of gonorrhea infections among men and women previously treated for gonorrhea. Most of these infections are reinfection caused by failure to treat all sex partners and not treatment failures.
  - Retesting should occur 3 months after treatment regardless if sex partners were treated

Test -of-Cure

- Not needed if treated with recommended regimens
- Need to perform test-of-cure if pharyngeal infection suspected when alternative regimens used
  - Cefixime has limited efficacy against pharyngeal infections
  - 14 days after treatment

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SITE SPECIFIC SCREENING

- Vaginal Sex
  - Men: Urine is Optimal Specimen
  - Women: Vaginal Swabs in Optimal Specimen in Women and Urine in Men
- Oral Sex
  - Men/Women: Pharyngeal Swab, Provider or Self-Collected
- Anal Sex
  - Receptive Partner: Rectal Swab, Provider or Self-Collected
- MSM be screened at least annually for chlamydia infection at sites of sexual contact, including the rectum and urethra; for gonorrhea, the guidelines recommend screening at the urethra, rectum, and pharynx.

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EXTRAGENITAL INFECTIONS IN WOMEN

Prevalence of Extragenital Infections:

- 0.6–35.8% for rectal gonorrhea (median 1.9%)
- 0–29.6% for pharyngeal gonorrhea (median 2.1%)
- 2.0–77.3% for rectal chlamydia (median 8.7%)
- 0.2–3.2% for pharyngeal chlamydia (median 1.7%).

- Most extragenital infections in women are asymptomatic.
- Furthermore, a significant number of women who test positive for rectal gonorrhea or chlamydia do not report anal sex.
- Extragenital screening increases the yield of detection of either gonorrhea or chlamydia at pharyngeal or rectal sites by approximately 6–50% or greater in women compared to screening urogenital specimens alone.

Chan, P, et. al. Extragenital Infections Caused by *Chlamydia trachomatis* and *Neisseria gonorrhoeae*: A Review of the Literature. Infectious Diseases in Obstetrics and Gynecology Volume 2016 (2016), Article ID 5758387, 17 pages
http://dx.doi.org/10.1155/2016/5758387.

EXTRAGENITAL INFECTIONS IN MSM

- Prevalence of extragenital infections due to N. gonorrhoeae or C. trachomatis:
  - 0.2–24% for rectal gonorrhea (median 5.9%)
  - 0.5–16.5% for pharyngeal gonorrhea (median 4.6%)
  - 2.1–23% for rectal chlamydia (median 8.9%),
  - 0–3.6% for pharyngeal chlamydia (median 1.7%)
- Similarly, among 21,994 MSM screened as part of the CDC STD Surveillance Network, composed of 42 STD clinics across the US, the prevalence of infection was 7.9% for pharyngeal gonorrhea, 2.9% for pharyngeal chlamydia, 10.2% for rectal gonorrhea, and 14.1% for rectal chlamydia. **Over 70% of extragenital infections in this sample would have been missed with urogenital screening alone.**
- In summary, urogenital testing alone misses a significant percentage of gonorrhea and chlamydia infections among MSM; if MSM were screened for urogenital infections alone, 14% to 85% of rectal and oropharyngeal gonorrhea and chlamydia infections would have been missed
- The majority of extragenital infections among MSM are asymptomatic
  - One study: only 5.1% of pharyngeal and 11.9% of rectal infections were symptomatic with the most common pharyngeal symptoms being pharyngitis (65%), localized lymphadenopathy (16%), and inflammation of the oral cavity (10%). The most common rectal symptoms were pruritus (36%) anal discharge (17%), burning (13%), inflammation (11%), pain (11%), and erythema around the anus (6%).

Chan, P, et. al. Extragenital Infections Caused by *Chlamydia trachomatis* and *Neisseria gonorrhoeae*: A Review of the Literature. Infectious Diseases in Obstetrics and Gynecology Volume 2016 (2016), Article ID 5758387, 17 pages
http://dx.doi.org/10.1155/2016/5758387.

EXTRAGENITAL INFECTIONS IN MSW

- A total of nine studies evaluated the prevalence of extragenital infections due to N. gonorrhoeae or C. trachomatis in MSW.
- The prevalence of extragenital infections among MSW in the studies reviewed ranged:
  - 0–5.7% for rectal gonorrhea (median 3.4%)
  - 0.4–15.5% for pharyngeal gonorrhea (median 2.2%)
  - 0–11.8% for rectal chlamydia (median 7.7%)
  - 0–22.0% for pharyngeal chlamydia (median 1.6%).
- These data represent studies that evaluated heterosexually identified men, some of whom may have engaged in sex with other men.

Chan, P, et. al. Extragenital Infections Caused by *Chlamydia trachomatis* and *Neisseria gonorrhoeae*: A Review of the Literature. Infectious Diseases in Obstetrics and Gynecology Volume 2016 (2016), Article ID 5758387, 17 pages
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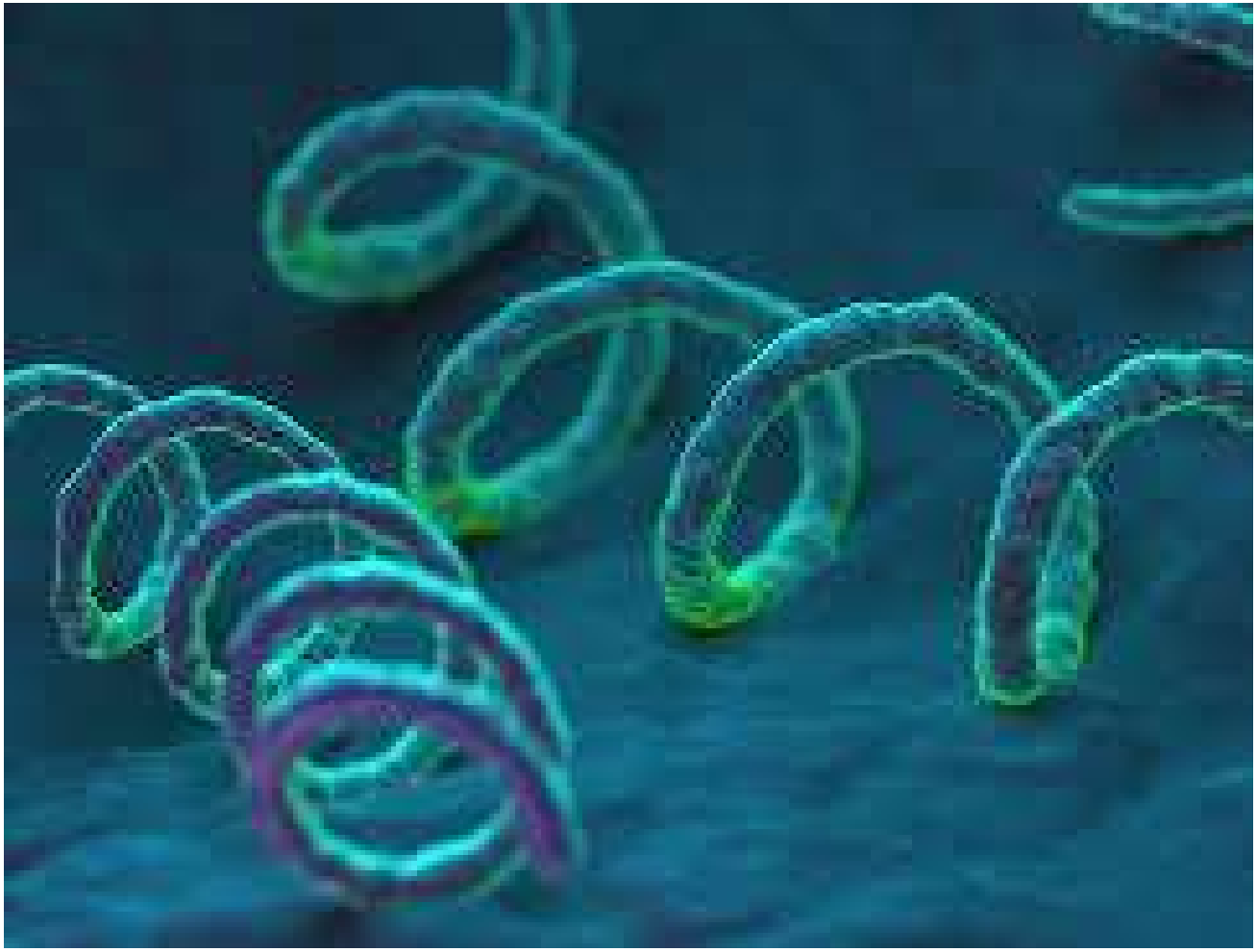

THE GREAT IMITATOR – HERPES OR SYPHILIS?

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SYPHILIS: *TREPONEMA PALLIDUM*

- Characterized by Stages
- "Great Imitator"
- During 2016, there were 27,814 reported new diagnoses of syphilis – Primary and Secondary – 17.6 % Increase from 2015
- CDC Call to Action
  - Syphilis Rates are Increasing among Women & Babies and Men throughout the U.S.

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THE INFECTIOUS STAGES OF SYPHILIS.

Primary

- Occurs after incubation
- Occurs in every case
- Usually one or more chancres at the site of exposure
- Most infectious stage of syphilis

Secondary

- Occurs any time after the eruption of the primary chancre (usually 4 – 6 weeks up to one year)
- The "great imitator" – rashes of different varieties, often on palms and soles

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SYPHILIS WITHOUT SYMPTOMS – LATENT

Early Latent

- Acquired Syphilis in Last Year
- No Symptoms
- Diagnosis:
  - Documented Seroconversion
  - Documented Symptoms
  - Sex Partner to Early Syphilis

Late Latent

- No symptoms
- Diagnosis as Late Latent if cannot definitively diagnosis as Early Latent

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MOTHERS CAN INFECT HER FETUS AT ANY STAGE OF SYPHILIS.

Congenital Syphilis

- Up to 40% of babies born to women with untreated syphilis may be stillborn or die from syphilis as a newborn
- Pregnant Women Screening
  - First Prenatal Visit
  - High Risk Women: 28 – 32 Weeks Gestation & At Delivery
- Evaluation and Treatment of Neonates, Consider:
  1. Diagnosis of Syphilis in Mother
  2. Appropriate Maternal Treatment
  3. Evidence of Syphilis is Neonate
  4. Comparison of Maternal Laboratory Results

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THERE ARE MANY MANIFESTATIONS OF SYPHILIS.

Neurosyphilis

- Congnitive Dysfunction
- Motor or Sensory Deficits
- Ophthalmic or Auditory Symptoms
- Cranial Nerve Palsies
- Specimen Source: CSF

Ocular Syphilis

- Can involve almost any eye structure.
- Ocular syphilis may lead to decreased visual acuity including permanent blindness.
- Eye redness, blurry vision, and vision loss.

Otosyphilis

- Sensorineural Hearing Loss
- Tinnitus
- Vertigo

Late Manifestations

- 15-30 yrs. after untreated infection
- Inflammatory lesions:
  - Cardiovascular System
  - Skin
  - Bone
  - Other Tissue

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WHO SHOULD BE TESTED FOR SYPHILIS?

- Pregnant females
- Partner(s) exposed to a positive syphilis case
- Blood donors
- MSM
  - Screen CT, GC and syphilis at 3 – 6 mo intervals if reporting multiple and anonymous sex partners
- HIV+ individuals should be tested once a year

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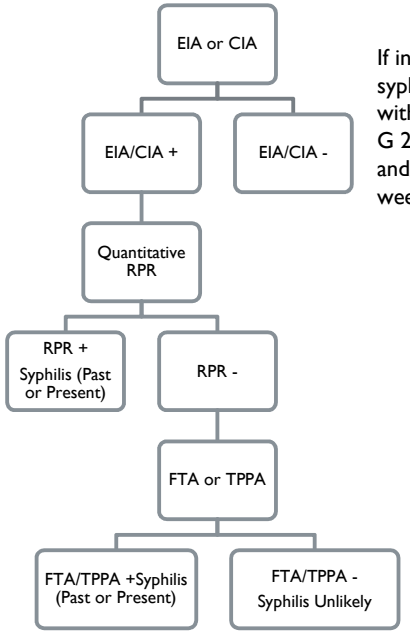
TESTING FOR SYPHILIS

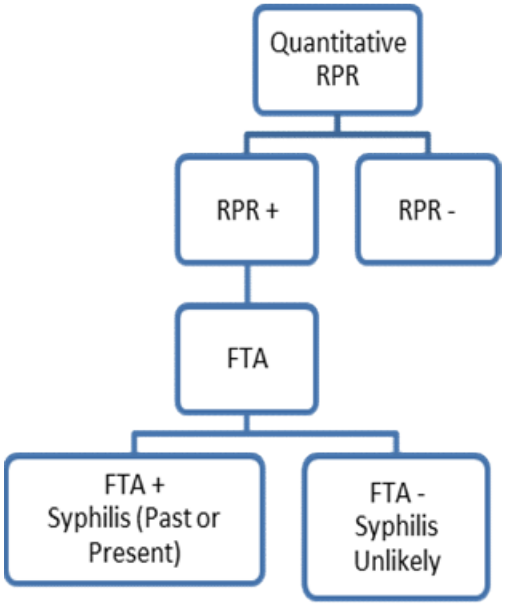
REVERSE SCREENING ALGORTIHM



Evaluate clinically, determine if treated for syphilis in the past, assess risk of infection, and administer therapy according to guidelines if not previously treated.

If incubating or primary syphilis is suspected, treat with benzathine penicillin G 2.4 million units IM x 1 and/or repeat in 2-4 weeks.

TRADITIONAL SCREENING



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THE TREATMENT FOR SYPHILIS HAS BEEN AVAILABLE SINCE 1943.

- Penicillin Still Works. Only Treatment Option for Pregnant Women. Dosage Depends on Stage.

Stage of Syphilis	Dosage
Primary	Benzathine penicillin G 2.4 million units
Secondary	Benzathine penicillin G 2.4 million units IM
Early latent	Benzathine penicillin G 2.4 million units
Late Latent	Benzathine penicillin G 7.2 million units total, administered as 3 doses of 2.4 million units IM each at 1-week intervals

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HPV

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HPV VACCINES ARE SAFE AND EFFECTIVE.

- 2 doses (shots) Series. Second Shot 6-12 months after first dose. *(Updated Dec. 2016)*
- CDC recommendations:
  - Girls: age 11 or 12; 13-26 if did not receive any or all doses when they were younger
  - Boys: age 11 or 12; 13-21 (MSM & HIV Positive Men Through Age 26)
- Why so young?
  - Need both doses before any sexual activity
  - Vaccine produces higher antibody that fights infection at this age

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HIV

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WHAT IS HIV?

- Human Immunodeficiency Virus
- HIV can lead to AIDS – Acquired Immunodeficiency Syndrome
- Attacks Immune System – CD4 Cells
- No effective cure currently exists, but with proper medical care, HIV can be controlled
- Medication – Live nearly as long as someone who doesn't have HIV

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HIV DISPARITIES IN US

- 2 out of every 5 patients newly diagnosed with HIV are youth
- African American MSM have 5x the national average of new HIV diagnoses
- One of every 2 women infected with HIV is African American
- New HIV diagnoses in Native American population increased 19% between 2005 to 2014 & 63% in MSM
- Transgender patients have 3x the national average of new HIV diagnoses

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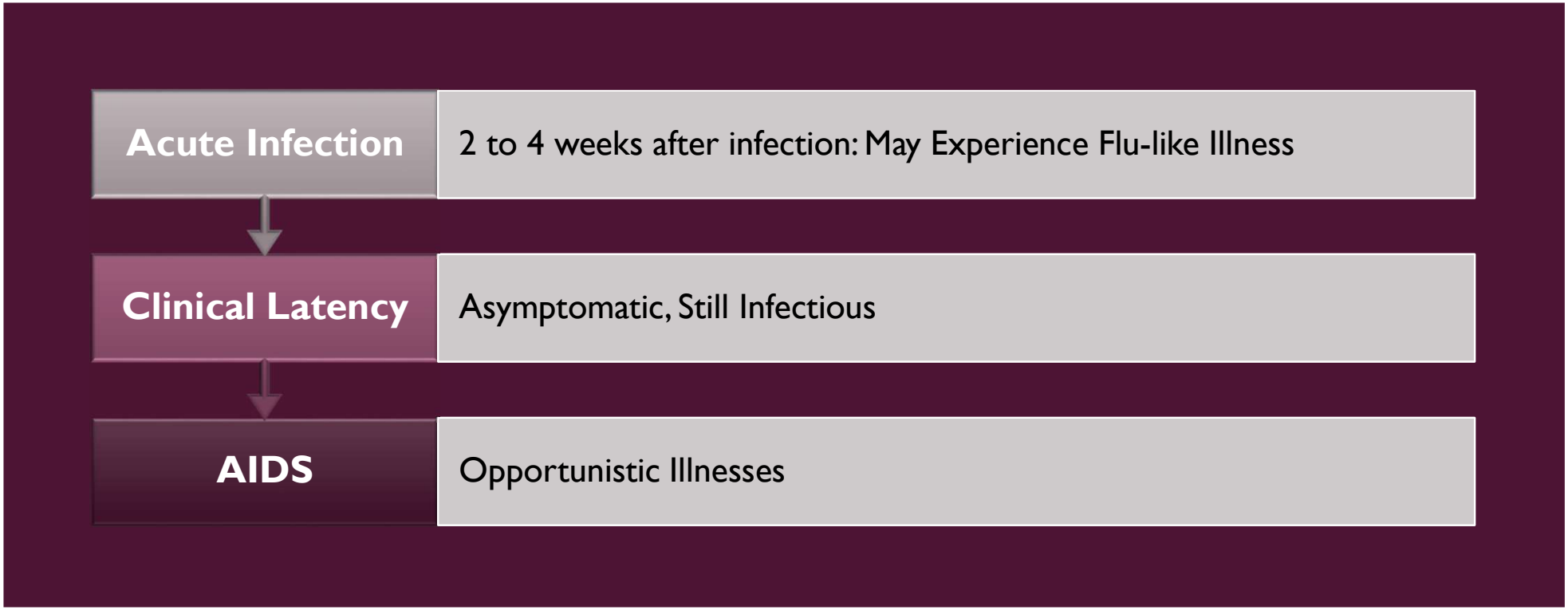

STAGES OF HIV INFECTIONS

HIV TREATMENT IS PREVENTION

- HIV can be controlled with antiretroviral therapy (ART)
- ART can help to stop the replication of HIV
- ART reduces the amount of virus (Viral Load) in blood and body fluids
- All individuals with HIV are recommended to be on HIV treatment
- U = U; Undetectable is Untransmittable
  - Prevention Access Campaign

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TRANSMISSION

- Vaginal or **Anal Sex**
- Sharing Needles or Syringes, Rinse Water or Other Drug Works
- Transmission from HIV positive mother to infant during pregnancy, at birth, or while breastfeeding
- Being stuck with a needle contaminated with HIV (health care workers)
- Rare Cases of HIV Transmission
  - Receiving blood transfusions, blood products, or organ or tissue transplants contaminated with HIV
  - Oral sex
  - Being bitten by a person with HIV.

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SHOULD I GET TESTED FOR HIV?

- **Everyone 13-64 should be tested at least once**
- Sex with HIV Positive Individual
- Persons who Injects Drugs
- Exchanged Sex for Drugs or Money
- Diagnosed with or Exposed to STDs
- Diagnosed with TB or Hepatitis
- Anonymous Sex Partners
- Pregnant Women – Each Pregnancy
- Men who Have Sex with Men

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TESTS AVAILABLE FOR HIV

NAT Tests – Nucleic Acid Tests

- Look for Virus is the Blood
- Not a Screening Test
- Detect HIV 10 to 33 Days After Exposure

Antigen/Antibody Tests

- 4th Generation – Identifies P24 Antigen
- Detect HIV 18 to 45 Days After Exposure

Antibody Test

- Only identifies Antibodies
- Rapid Test or Home Tests
- Rapid Test Used By NDDoH – 2nd Generation
- Detect HIV 23 to 90 Days After Exposure

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REDUCING RISK TO HIV

Increased testing & linkage to care	Delayed or fewer partners	Less risky activities	Increased condom use	Empowerment and negotiation skills
Reducing alcohol & drug use	Reduce psychosocial barriers	HIV PEP and PrEP	STI treatment	Circumcision

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WHAT IS PREP?

- An individual who is not infected with HIV takes ARV agent(s) before potential HIV exposure.
  - In 2012, the FDA approved TRUVADA as PrEP for uninfected individuals who are at high risk of HIV infection.
  - PrEP must be taken every day to be most effective.

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CDC PREP GUIDANCE: WHO IS RECOMMENDED FOR PREP?

- Daily oral PrEP is recommended for adults at substantial risk of acquiring HIV infection

	MSM	Heterosexual Women and Men	Injection Drug Users
Detecting substantial risk of acquiring HIV infection	▪ HIV-positive sexual partner ▪ Recent bacterial STI ▪ High number of sex partners ▪ History of inconsistent or no condom use ▪ Commercial sex work	▪ HIV-positive sexual partner ▪ Recent bacterial STI ▪ High number of sex partners ▪ History of inconsistent or no condom use ▪ Commercial sex work ▪ In high-prevalence area or network	▪ HIV-positive injecting partner ▪ Sharing injection equipment ▪ Recent drug treatment (but currently injecting)

MSM=men who have sex with men; STI=sexually transmitted infection.

CDC. Preexposure Prophylaxis for the Prevention Of HIV Infection in the United States -- 2014: A Clinical Practice Guideline. Section: Summary of Guidance for PrEP Use. May 2014. www.cdc.gov/hiv/pdf/guidelines/PrEPguidelines2014.pdf. Accessed 1/19/15.

PARTNER SERVICES

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PARTNER SERVICES IN NORTH DAKOTA – WHAT IS THE HEALTHCARE PROVIDERS ROLE?

- **Partner Services:** Continuum of Clinical Evaluation, Treatment, Counseling, Testing and Treatment Designed to Increase Number of Infected Persons Brought to Treatment and to Disrupt Transmission Networks
- ND Field Epidemiologists: Gonorrhea, Complicated Chlamydia (<14, PID, Pregnant), Syphilis, HIV
- Chlamydia: Healthcare Provider Responsibility
- Partner Services Most Effective if Healthcare Provider Involved

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WS3
BN2

CHLAMYDIA/GONORRHEA PATIENT INTERVIEW

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF DISEASE CONTROL
SFN 61113 (08-2016)

You are being tested and/or treated for a sexually transmitted disease (STD). It is important for your health that your sexual partners are also treated for this infection. Sex partners and people infected with STDs may not know they are infected because many time people do not have symptoms, or only mild symptoms. It is important that **ALL** of your current and former sex partners are treated to prevent you from becoming reinfected, and to protect others from being infected.

Your name will never be used if the North Dakota Department of Health or your healthcare provider refers your partners in for testing and treatment. Your information is strictly confidential.

Please list all of the people you have had sex with in the last 3 months. If you have not had sex in the last 3 months, list your last sex partner. Please provide as much information as you can.

It is essential you wait seven (7) days after you and your partner have been treated before you have sex again. Do not have sex again with your current partner until they have been treated.

Patient Information:

First Name:	*Last Name:*		*Date of Birth:*	
Street Address:	*City:*	*State:*	*ZIP Code:*	*Telephone Number:*
Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Refused			*Ethnicity:* ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Refused	
Gender: ☐ Male ☐ Female	*Pregnancy Status:* ☐ Not Pregnant ☐ Pregnant ☐ NA		If Pregnant, Due Date:	

Risk History Information:

Are you a resident/staff member of correctional facility?	☐ Yes ☐ No
Have you ever used intravenous/injection drugs?	☐ Yes ☐ No
Have you ever used non-injection drugs?	☐ Yes ☐ No
Have you ever had sex while high/intoxicated?	☐ Yes ☐ No
Have you ever had sex with an injection drug user?	☐ Yes ☐ No
Have you ever traded sex for drugs or money?	☐ Yes ☐ No
Have you ever had sex with an anonymous sex partner?	☐ Yes ☐ No
Have you ever met sexual partners on the internet?	☐ Yes ☐ No
Total number of sex partners in last 12 months:	
Number of Female Partners	
Number of Male Partners	
How frequently does the patient use condoms during sex?	☐ Always ☐ Not that Often ☐ Never ☐ Most of Time

Patient Initials:

Sex Partner History*

Please list all information on any sexual partners within the last 90 days or the last sexual partner if exposure greater than 90 days ago.

Partner Name:		*Date of Birth or Approximate Age:*	Gender: ☐ Male ☐ Female
Address:	*City:*	*State:*	*Telephone Number:*
Email Address and/or Username (Facebook, Twitter, Instagram, Snapchat, etc.)			
Date of First Exposure:		*Frequency of Exposure:*	
Date of Last Exposure:		***Note for Exposure Dates:*** *Include approximate dates if exact date unknown.*	
Any notes about this person if name and location are unknown:			
Choose one of the following: ☐ This partner is here with me and is being treated today. ☐ I will bring my current partner with me to the clinic. ☐ I will contact this partner and refer them to the clinic. ☐ I have no way of contacting this partner.		*If partner is a female, is she pregnant?* ☐ Yes ☐ No	
For Provider Use:			
Was this partner tested? ☐ Yes ☐ No		*Partner Treatment Type:*	
Partner Specimen Collection Date:		*Partner Treatment Date:*	
Partner Results:		*Was partner treated via EPT?* ☐ Yes ☐ No	

Partner Name:		*Date of Birth or Approximate Age:*	Gender: ☐ Male ☐ Female
Address:	*City:*	*State:*	*Telephone Number:*
Email Address and/or Username (Facebook, Twitter, Instagram, Snapchat, etc.)			
Date of First Exposure:		*Frequency of Exposure:*	
Date of Last Exposure:		***Note for Exposure Dates:*** *Include approximate dates if exact date unknown.*	
Any notes about this person if name and location are unknown:			
Choose one of the following: ☐ This partner is here with me and is being treated today. ☐ I will bring my current partner with me to the clinic. ☐ I will contact this partner and refer them to the clinic. ☐ I have no way of contacting this partner.		*If partner is a female, is she pregnant?* ☐ Yes ☐ No	
For Provider Use:			
Was this partner tested? ☐ Yes ☐ No		*Partner Treatment Type:*	

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WS3 I would include image of form so they know for sure which form you are referring to.
Weninger, Sarah, 1/8/2018

BN2 added picture
Brenton Nesemeier, 1/8/2018

GENERAL PROCESS FOR PARTNER SERVICES

- Positive case or contact to a positive case is identified
  - 1st – Three phone calls/text messages are attempted at various times throughout the day (morning, noon, afternoon, evening)
    - Internet notification can also be utilized here if deemed necessary
      - Facebook, Phone Apps (Grindr, Tinder, Jack'd etc.)
  - 2nd – A letter is mailed to the address given to us on file
    - Syphilis and HIV cases (depending on circumstances) certified letters are sent requesting individual to contact us
  - 3rd – Home visits can be made if necessary
- Case returns call and agrees to be interviewed
  - CT/GC and syphilis are usually done by phone
  - HIV and some syphilis cases are done in person
- Contact exposures
  - Request information on where they are going to go for testing to ensure that they are adequately tested and properly treated

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RESOURCES

- NDDoH: www.ndhealth.gov/HIV
- National HIV Curriculum: https://aidsetc.org/nhc
- STD Education: https://www.cdc.gov/std/training/default.htm
- HIV PrEP: https://www.cdc.gov/hiv/risk/prep/index.html
- STD Treatment Guidelines: https://www.cdc.gov/std/tg2015/default.htm
- NDDoH Field Epidemiologists: http://www.ndhealth.gov/Disease/Contacts/AreaCall.aspx

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CONTACT INFORMATION

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